



J. Arthur Trudeau Memorial Center  
Shared Living Services

**SHARED LIVING PROVIDER- APPLICATION**

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Co-Applicant: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell# \_\_\_\_\_

Do you live in a    House    Condo    Apartment    Mobile/Modular Home    Other

Do you Rent or Own?    Do you have renter's or homeowner's insurance?

Do you have landlord approval to have a non-related individual move into your home?    Yes    No    Haven't Asked Yet

How long have you lived at your current address? \_\_\_\_\_

Total # of Rooms in your home: \_\_\_\_\_ # of Bedrooms: \_\_\_\_\_

Do you have a valid driver's license?    Yes    No

Do you have the minimum vehicle insurance required by the State Of Rhode Island?    Yes    No

If you do not drive, how would you ensure transportation for an individual?  
Please be specific as you will be responsible for most transportation.

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**APPLICANT – Education**

Please complete and attach a copy of an updated resume. Please include any information you feel is relevant concerning your education (i.e., workshops, inservice trainings, etc.)

<b>Name &amp; Location</b>	<b>Dates Attended</b>	<b>Major</b>
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High School: \_\_\_\_\_

College: \_\_\_\_\_

Other: \_\_\_\_\_

**Interest:** Why do you want to be a Shared Living Home Provider?

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2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Challenges:** What do you foresee to be the greatest challenges involved in welcoming an adult with disabilities into your household? Please be specific.

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Have you considered the possibility of lifestyle changes that your family may need to make in order to welcome an adult with disabilities into your household?  
Yes      No

Are you and your family willing to make lifestyle changes if necessary to accommodate a particular individual?  
Yes      No      Not Sure

**Personal References:**

Please provide the following information for 4 character references. **Please note**, at least one reference must be from a relative, and at least two must be from a non-relative who you have known for more than five years.

Name	Address	phone	relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

**APPLICANT – Employment History**

Starting with present or most recent employer, please account for all employment. Use additional pages if needed.

COMPANY NAME \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Supervisor: \_\_\_\_\_  
Job Title/Description of Duties \_\_\_\_\_  
Reason For  
Leaving: \_\_\_\_\_  
\_\_\_\_\_  
Employment Dates: From \_\_\_\_\_ To: \_\_\_\_\_

COMPANY NAME \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Supervisor: \_\_\_\_\_  
Job Title/Description of Duties \_\_\_\_\_  
Reason For  
Leaving: \_\_\_\_\_  
\_\_\_\_\_  
Employment Dates: From \_\_\_\_\_ To: \_\_\_\_\_

COMPANY NAME \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Supervisor: \_\_\_\_\_  
Job Title/Description of Duties \_\_\_\_\_  
Reason For  
Leaving: \_\_\_\_\_  
\_\_\_\_\_  
Employment Dates: From \_\_\_\_\_ To: \_\_\_\_\_

COMPANY NAME \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Supervisor: \_\_\_\_\_  
Job Title/Description of Duties \_\_\_\_\_  
Reason For  
Leaving: \_\_\_\_\_  
\_\_\_\_\_  
Employment Dates: From \_\_\_\_\_ To: \_\_\_\_\_

**APPLICANT – Members of Household:**

Please list all adults and children residing in your home at this time. All of these people will be part of the interview process; all adults must complete a criminal record check and will receive reference checks.

Name:	Relationship:	Date of Birth
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____

Do you have any frequent visitors/overnight guests?    Yes    No

Please describe your experience with individuals with disabilities. This may include volunteer experiences and providing respite care.

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**PART II – APPLICANT – HISTORY**

Please answer the following questions in detail. All of this information will be discussed on an individual basis during personal interview.

Please provide the name and contact information for your primary care physician. Your physician will be asked to complete a simple form providing his or her opinion on your ability to become a Shared Living Provider based on your physical health.

Physician's name	Address	Phone
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Describe any major medical problems you have had treatment for in the past 10 years.

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List any medication you are currently taking:

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Do you drink alcoholic beverages? Yes No

If yes, how many drinks do you usually have in a week? \_\_\_\_\_

Have you or any member of your household ever been treated for, or had a drug or alcohol-related concern? Yes No

If yes, please explain: \_\_\_\_\_

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Do you or other members of the household smoke?    Yes    No

Do you have any pets?    Yes    No, if yes, please list:

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Have you or any member of your household ever been engaged in counseling, psychiatric or psychological treatment?    Yes    No  
If yes, please explain: \_\_\_\_\_

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Have you had any motor vehicle violations (including accidents) in the last three (3) years?    Yes    No  
If yes, please explain \_\_\_\_\_

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Have you or any member of your family/household ever been in foster care or out-of-home placements?    Yes    No  
If yes, please explain \_\_\_\_\_

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Have you had any past experiences that may interfere with your ability to work with an individual who has been physically or sexually abused? Yes No  
If yes, please explain:\_\_\_\_\_

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Have you ever been debarred, excluded or otherwise ineligible for participation in any federal health care program such as Medicare or Medicaid? Yes No  
If yes, please explain:\_\_\_\_\_

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Have you or any member of your household ever had a charge of abuse or neglect substantiated against you? Yes No

Have you or any member of your household been convicted of a misdemeanor or felony in any jurisdiction within or outside the state of Rhode Island? Yes No  
If yes, please explain:\_\_\_\_\_

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Do you have any friends or relatives who are Shared Living Home Providers?  
Yes No  
If yes, please explain:\_\_\_\_\_

Have you ever been a Home Provider or Foster Care provider before? Yes No  
If yes, please explain \_\_\_\_\_

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Please describe your interests and hobbies

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Would you be willing to provide respite care, which is a temporary, shorter term living arrangement ? Yes No

Do you understand that as a contracted Home Provider, you will not be an employee of the J. Arthur Trudeau Memorial Center, and will not be entitled to healthcare or other benefits afforded to agency employees? Yes No

Do you understand that as a potential Home Provider, there is a series of training requirements that must be met prior to contracting with the Trudeau Center and that you will not receive any compensation for this pre-service training?

Yes No

You may have a job outside the home, but you will have specific obligations as a home provider, as stated in a contract between you and The J. Arthur Trudeau Memorial Center. You will have the opportunity to review the contract prior to making any decision.

Thank you for taking the time to fill out this application packet completely. Please read the important statement below, then sign and date this page.

I authorize full review and verification of my experience/education as well as verification of any and all information provided by me or any member of my household for purposes of advancing to the next step in the process of becoming a Shared Living Home Provider with the J. Arthur Trudeau Memorial Center. I release from liability any person giving or receiving such information. Any material misrepresentation or deliberate omission of a fact on this request for consideration may be justification for refusal of, or if contracted with, termination of said contract. I understand that the J. Arthur Trudeau Memorial Center will conduct the following clearance checks on all members of my household who are over the age of 18:

- Criminal (BCI)
- Dept. of Motor Vehicle
- Office of the Inspector General (OIG)
- DCYF clearance .

I have read and understand the above.

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Signature of Applicant

Date